Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL049015 | A. BUILDING: _____ B. WING _____ | 11/16/2016 |

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| JURNEY'S ASSISTED LIVING | 1942 VAN HAVEN DRIVE STATESVILLE, NC 28625 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on November 15 - 16, 2016. | D 000 | Response Preface<br><br>The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the stated deficiencies are accurate.<br><br>The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider.<br><br>The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings:<br>(1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or<br>(2) serve, in any way, to facilitate or promote action by any third party against the Provider.<br><br>Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. | |
| D 113 | 10A NCAC 13F .0311(d) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116degrees F (46.7 degrees C). This rule applies to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on record review, observations and resident and staff interviews, the facility failed to ensure hot water temperatures throughout the facility were maintained at or between 100 and 116 degrees Fahrenheit (F), as checked with a calibrated thermometer in 5 of 10 resident bathroom sinks, 2 of 10 resident showers and 2 of 2 common resident sinks.<br><br>The findings are:<br><br>Review of the most current Environmental Health inspection report dated 04/19/16 revealed:<br>-An overall score of 94.<br>-A 2 point deduction under the category of Toilet, Handwashing, Laundry and Bathing Facilities, in the subcategory of "Lavatory and bathing hot water between 100 and 116 degrees | D 113 | It is this community's policy and normal practice to assure water temperatures are within the guidelines outlined at 10A NCAC 13F.0311(d).<br><br>The community had in place policies and procedures designed to maintain these goals.<br><br>Routine monitoring, consultant audits, staff, visitor, resident use and feedback, Quality Assurance audits and meetings, and various | 12/31/16 |



Plan of Correction received and accepted.
Nurse Consultant I
1/19/17

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| D 113 | Continued From page 1<br>F[ahrenheit]."<br>-The additional comments "Measured hot water throughout facility including: shared shower rooms, resident rooms, activity rooms, and day rooms between 137 F - 142 F. Hot water heater was set to 135 F. Reset hot water heater to 105 F during inspection. Maintain logs of water temperatures. Water heating facilities shall provide hot water within the temperature range of 100 degrees F to 116 degrees F at all lavatories and bathing facilities."<br><br>Review of a Water Temperature Checks Log dated 09/28/16 revealed:<br>-The initials of a staff member (identified as those of Staff A, Housekeeper).<br>-A range of temperatures documented for 9 of 45 resident rooms from 102 F to 112 F.<br>-A range of temperatures documented for resident common areas (Resident Bath A and common restrooms on Hall C1 and Hall C2) from 108 F to 113 F.<br><br>Review of a Water Temperature Checks Log dated 10/31/16 revealed:<br>-The first name of a staff member (identified as Staff A, Housekeeper).<br>-A range of temperatures documented for 10 of 45 resident rooms from 96 F to 116 F.<br>-A range of temperatures documented for resident common restrooms on Hall C1 and Hall C2 from 96 F to 116 F.<br><br>Observation on 11/15/16 at 9:20AM of Resident Room #45 bathroom (located at the end of Hall C2) revealed a water temperature at the sink of 122 F.<br><br>Observation on 11/15/16 at 9:40AM of Resident Room #33 bathroom (located in the middle of Hall | D 113 | Continued from Page 1<br>other quality assurance measures are examples of the many components utilized.<br><br>Maintenance routinely conducts random water temperature checks throughout the facility on a scheduled basis or more often if an issue were to be suspected and/or identified.<br><br>Since the last water temperature check conducted a few days prior to 11/15/16, residents and staff had not encountered any cold or hot water concerns. Water temperatures were within 100-116 degrees.<br><br>**Action Plan**<br><br>**Measures to Correct**<br>An adjustment was immediately made to the affected hot water heater to regulate the temperature on 11/15/16.<br><br>A plan of protection was immediately implemented on 11/15/16. (See Attachment #1)<br><br>Monitoring continued daily until a plumber could inspect the entire system.<br><br>A plumber inspected the hot water system on 11/30/16. No issues were found with the thermostat or heating unit. The plumber did replace a circulating pump during the service call. (See Attachment #2)<br><br>**Measures to Prevent**<br>A procedural change was made regarding the type of water temperature monitoring device used by maintenance. Starting on 11/15/16, water temperature monitoring devices used by community staff are the glass bulb thermometer. Maintenance discontinued use of the laser style thermometer. | |

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| D 113 | Continued From page 2<br>C2) revealed a water temperature at the sink of 122 F.<br><br>Observation on 11/15/16 at 9:58AM of Resident Room #40 (located in the middle of Hall C1) revealed a water temperature at the sink of 122 F.<br><br>Observation on 11/15/16 at 9:58AM of Resident Room #42 (located at the end of Hall C1) revealed a water temperature at the sink of 122 F.<br><br>Observation on 11/15/16 at 10:05AM of Resident Room #35 (located in the middle of Hall C1) revealed a water temperature at the sink of 122 F.<br><br>Confidential interviews with 8 residents during a tour of the facility on 11/15/16 revealed:<br>-One resident stated the water had never felt too hot in her private bath.<br>-A second resident stated the water was never too hot, it was usually a little cool in her private bath.<br>-A third resident stated staff assist her with bathing, adjust the water temperatures, and the water had never been too hot or too cold.<br>-A fourth resident stated the water had felt too hot to him, but staff assist him with bathing and adjust the water temperatures.<br>-A fifth resident stated a personal care aide assisted her and her roommate with showers in their room and water temperature was adjusted accordingly.<br>-A sixth resident stated he had no problems with water temperature as "it's adjustable."<br>-A seventh resident stated she sometimes took showers in her room and sometimes a bath in the tub room, but there had never been any problems | D 113 | Continued from Page 2<br>**Monitoring**<br>Maintenance will continue to monitor hot water temperatures randomly throughout the facility at least monthly. During November water temperature checks were conducted at least five (5) days per week. During December water temperature checks were conducted at least weekly. (Attachment #3)<br><br>Results of findings will be reported to the Administrator and reviewed in the quarterly Quality Assurance meetings. | |

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| D 113 | Continued From page 3<br>with scalding.<br>-An eighth resident stated she was able to adjust the temperature of her shower and there had never been any scalding.<br><br>Interview on 11/15/16 at 10:10AM with the Maintenance Director revealed:<br>-Water temperatures were checked "periodically," or once a month.<br>-He used an electronic laser-type thermometer with which he would "just shoot it [the stream of water]" to obtain a temperature reading.<br>-He would obtain a cup of ice water for an ice water bath required to calibrate his and the surveyor's thermometers.<br><br>Observation on 11/15/16 at 10:15AM of thermometer calibration using an ice water bath revealed:<br>-The surveyor's glass bulb thermometer read 32 F when immersed in the ice water bath for approximately one minute.<br>-The Maintenance Director's electronic laser-type thermometer first gave a digital reading of 39 F when the laser beam was shot from the device, approximately 8 inches away from the surface of the ice water bath.<br>-The Maintenance Director's electronic laser-type thermometer gave a final reading of 32.6 F when the laser beam was shot from the device approximately 1 inch from the surface of the ice water bath.<br>-Imprinted on the electronic laser-type thermometer was a manufacture's name and model number.<br><br>A second interview on 11/15/16 at 10:15AM with the Maintenance Director revealed:<br>-The most current temperature checks done at the facility were documented on the Water | D 113 | | |

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| D 113 | Continued From page 4<br><br>Temperature Checks Log dated 10/31/16.<br>-Staff A, Housekeeper would sometimes do the monthly temperature monitoring and complete the log.<br>-There were two water heaters, one supplying the kitchen and the other supplying resident bathrooms.<br>-A mixing valve or "ceramic" was replaced in May 2016 when it was determined water temperatures were "not accurate."<br><br>Review of the on-line Owner's Manual for the electronic laser-type thermometer, last revised in 2014 revealed:<br>-Listed applications for use included detecting hot and cold spots around door and window seals, checking the temperature of air vents, checking the exterior and interior surfaces of household items and appliances and automotive applications.<br>-Checking water temperature was not listed as an application.<br>-"Temperature readings can only be measured on a target surface."<br>-Accuracy of readings is plus (+) or minus (-) 5 degrees C (Centigrade) of the actual temperature, assuming ambient temperature of 25 +/- 1 degree C.<br><br>Observation on 11/15/16 at 10:32AM by the surveyor and Maintenance Director of Resident Room #1 bathroom (located at the end of Hall A) revealed:<br>-A sink water temperature of 122 F by the surveyor and 119 F by the Maintenance Director.<br>-A shower water temperature of 122 F by the surveyor and 113 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 10:36AM by the surveyor and Maintenance Director of Resident | D 113 | | |

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| D 113 | Continued From page 5<br><br>Room #7 bathroom (located at the middle of Hall A and currently unoccupied) revealed:<br>-A sink water temperature of 122 F by the surveyor and 107 F by the Maintenance Director.<br>-A shower water temperature of 120 F by the surveyor and 101 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 10:40AM by the surveyor and Maintenance Director of Resident Room #4 bathroom (located closer to the intersection of the nursing station and Hall A) revealed:<br>-A sink water temperature of 120 F by the surveyor and 111 F by the Maintenance Director.<br>-A shower water temperature of 96 F by the surveyor and 87 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 10:52AM by the surveyor and Maintenance Director of Resident Bath A (located closer to the intersection of the nursing station and Hall B) revealed:<br>-A sink water temperature of 120 F by the surveyor and 112 F by the Maintenance Director.<br>-A whirlpool water temperature of 116 F by the surveyor and 114 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 10:55AM by the surveyor and Maintenance Director of Resident Room #14 bathroom (located closer to the intersection of the nursing station and Hall B) and unoccupied revealed:<br>-A sink water temperature of 120 F by the surveyor and 115 F by the Maintenance Director.<br>-A shower water temperature of 100 F by the surveyor and 101 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 11:06AM by the surveyor and Maintenance Director of Resident Room #45 bathroom (located at the end of Hall C2 and a recheck of temperature with a | D 113 | | |

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| D 113 | Continued From page 6<br>calibrated thermometer) revealed:<br>-A sink water temperature of 118 F by the surveyor and 115 F by the Maintenance Director.<br>-A shower water temperature of 112 F by the surveyor and 102 F by the Maintenance Director.<br><br>Observation on 11/15/16 at 11:10AM by the surveyor and Maintenance Director of the common Women's Restroom (located near the intersection of Hall C1 and C2) revealed a sink water temperature of 120 F by the surveyor and 112 F by the Maintenance Director.<br><br>Interview on 11/15/16 at 11:16AM with the Maintenance Director, Resident Care Director and Administrator revealed:<br>-None of them were aware of or had received staff or resident complaints about water temperatures being too hot.<br>-Water temperatures were checked monthly as this was a resident safety issue that required monitoring.<br>-They could not explain why water temperatures were higher than 116 F this particular day.<br>-The hot water tank temperature serving residents would be adjusted by the Maintenance Director immediately with monitoring of temperatures throughout the day.<br><br>Observation on 11/15/16 at 11:25AM of the locked Hot Water Heater space (accessed from outside), accompanied by the Maintenance Director, revealed:<br>-Two 110 gallon water heaters, each with a digital temperature display.<br>-The Maintenance Director identified the tank for resident rooms, with the digital display reading 116 F.<br>-The Maintenance Director turned the temperature down on the resident water tank | D 113 | | |

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| D 113 | Continued From page 7<br>from 116 F to 111 F.<br><br>Interview on 11/16/16 at 8:00AM with Staff A, Housekeeper revealed:<br>-He obtained water temperatures when the Maintenance Director was unable to get them.<br>-Water temperatures were obtained once a month.<br>-There was a complaint from a resident approximately two months prior (he could not remember the resident) about water being hot, which he reported to the Maintenance Director.<br>-"A few months ago" he obtained one high water temperature and he told the Maintenance Director to adjust the water heater temperature as only the Maintenance Director could do this.<br>-Overall, he had not received any complaints from residents or staff about water being too hot .<br><br>Review of a Water Temperature Checks Log dated 11/15/16 at 3:30PM revealed:<br>-The initials of a staff member (identified as those of the Maintenance Director).<br>-A range of temperatures documented for 12 of 45 resident rooms for shower temperatures from 100 F to 113 F and for sink temperatures from 98 F to 115 F.<br>-A range of temperatures documented for resident common areas (Resident Bath A, Storage Room #4 and common restrooms on Hall C1) from 104 F to 113 F.<br><br>Review of a Water Temperature Checks Log dated 11/16/16 at 10:30AM revealed:<br>-The initials of a staff member (identified as those of the Maintenance Director).<br>-A range of temperatures documented for 13 of 45 resident rooms for shower temperatures from 101 F to 108 F and for sink temperatures from 101 F to 111 F. | D 113 | | |

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| D 113 | Continued From page 8<br>-Temperatures documented for resident common areas (Resident Bath A and common men's restroom on Hall C2) at 104 F.<br>_____<br>A Plan of Protection was obtained from the Administrator on 11/15/16 and included:<br>-Staff working at the time the high water temperatures were found on 11/15/16 were immediately made aware by the Resident Care Director to use caution in regards to using hot water for any personal care tasks, and water temperatures were in the process of being adjusted to a more safe temperature.<br>-During lunch on 11/15/16 residents were made aware by the Resident Care Director to use caution in regards to using hot water for any reason and encouraged to receive assistance from a staff member when needing to use hot water until the temperatures had been adjusted to a more safe temperature range. Reminders would be provided daily until the issue was resolved (the facility also posted signage throughout the building warning of caution when using hot water).<br>-The Maintenance Director checked the hot water tank temperature around 11:30AM on 11/15/16 and it was adjusted to decrease current water temperatures by 4 to 6 F for the rooms identified as being out of the 100 F to 116 F.<br>-The Maintenance Director would conduct random water temperature checks at least three times throughout the day from 11/15/16 through 11/16/16, which would be recorded and monitored, and then daily when on duty to 11/30/16, which would be reported to and discussed with the Administrator.<br>-The Maintenance Director would contact the facility's plumber to inspect the hot water tank and suggest a resolution should the hot water tank temperature adjustment not consistently maintain | D 113 | | |

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| D 113 | Continued From page 9<br>water temperatures.<br>-If water temperatures were consistently maintained during November 2016, the Maintenance Director would be responsible for randomly conducting hot water temperature checks throughout the facility at least once weekly through 12/31/16, which would be recorded and discussed with the Administrator.<br><br>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2016. | D 113 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure follow-up with a physician for 1 of 5 sampled residents (Resident #1) to obtain a hard (written) prescription for an ordered as-needed narcotic sleep medication, which would permit the pharmacy to dispense the medication.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 08/04/16 revealed diagnoses which included depression, failure to thrive and osteoarthritis.<br><br>Review of Resident #1's Resident Register revealed an admission date of 08/08/16. | D 273 | It is this community's policy and normal practice to assure referral and follow-up to meet the routine and acute health care needs of our residents utilizing the guidelines outlined at 10A NCAC 13F.0902(b).<br><br>The community has policies and procedures designed to maintain these goals. Routine chart audits, nurse and pharmacy consultant audits, Quality Assurance audits and meetings, and other various quality assurance measures are examples of the many components utilized.<br><br>**Action Plan**<br><br>**Measures to Correct**<br><br>Resident #1's physician was contacted by the Resident Care Director (RCD) on 11/15/16 to clarify or expedite a prescription. Resident #1's physician sent a hard copy prescription (hand written) to the pharmacy on 11/16/16. Pharmacy delivered pills on 11/16/16.<br><br>**Measures to Prevent**<br><br>A procedural change was made with the community's referral and follow-up communication process between contract | 11/24/16 |

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| D 273 | Continued From page 10<br><br>Review of a physician's Progress Note dated 10/15/16 for Resident #1 revealed:<br>-Resident #1 "complained of difficulty sleeping sometimes."<br>-A plan by the physician to prescribe Ambien 5mg at bedtime, as needed. (Ambien is a narcotic medication used to induce and maintain sleep.)<br><br>Record review for Resident #1 revealed a medication order dated 10/15/16 for Ambien 5mg, 1 tablet at bedtime as needed for insomnia.<br><br>Review of Resident #1's electronic Medication Administration Records (eMARs) for October and November 2016 revealed:<br>-An entry on both the October and November 2016 MARs for zolpidem 5mg (generic Ambien) 1 tablet at bedtime as needed for insomnia.<br>-No zolpidem had been documented as administered in either October or November 2016.<br><br>Observation on 11/15/16 at 4:00PM of Resident #1's medications on hand in the medication cart revealed no zolpidem 5mg tablets available to administer.<br><br>Interview on 11/15/16 at 4:02AM with a Medication Aide (MA) revealed Resident #1 did not have any Ambien "because the insurance would not pay for it."<br><br>Interview on 11/16/16 at 9:25AM with the Resident Care Director (RCD) revealed:<br>-She was not sure who was responsible for calling the physician to obtain a hard (written) prescription for narcotic medications.<br>-She was not aware the facility did not have any Ambien available to administer to Resident #1 per | D 273 | Continued from Page 10<br><br>pharmacy to better reduce the risk of medication(s) not being delivered. (See Attachment #3)<br><br>The shift supervisor (SIC) or RCD will ensure communication between pharmacist and physician regarding medication concerns involving delivery and/or availability until a resolution has been reached (the medication is delivered, physician orders to hold, or physician changes order, etc.).<br><br>The community's RCD re-educated SICs and Medication Aids (MAs) from 11/16/16 through 11/24/16 about referral and follow-up procedures. The SIC and MA will immediately report to the RCD any medication that is not readily available for administration.<br><br>**Monitoring**<br><br>As part of the Community's Quality Assurance process, the RCD, nurse consultant and pharmacy consultant will monitor at least ten (10) new orders or order changes and subsequent medication deliveries monthly for three (3) months and then quarterly for the next three (3) quarters and report findings to the Administrator and QA committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL049015 | A. BUILDING: _____ B. WING _____ | 11/16/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JURNEY'S ASSISTED LIVING | 1942 VAN HAVEN DRIVE STATESVILLE, NC 28625 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 273 | Continued From page 11<br>physician's orders.<br>-The pharmacy usually faxed back the medication order with a note explaining why they could not dispense the medication.<br>-The pharmacy didn't fax the facility back in this case.<br><br>Interview on 11/16/16 at 11:30AM a second MA revealed:<br>-Resident #1's Ambien was not in the facility because his insurance would not pay for it.<br>-The pharmacy usually sent the facility something back to explain why the medication order had not been filled.<br>-She had informed the resident's physician, who comes to the facility weekly, that Resident #1 still did not have his Ambien.<br><br>Telephone interview on 11/16/16 at 12:00PM with a pharmacist at the contract pharmacy revealed:<br>-They had received a hard prescription for Resident #1's Ambien today (11/16/16), and "it will be sent today in the tote."<br>-There was no problem with Resident #1's insurance, the pharmacy simply needed a hard prescription to dispense the Ambien.<br>-The pharmacy notified the facility they needed a hard prescription for Resident #1's Ambien when it was initially ordered on 10/15/16.<br>-Even though they had dispensed the medication, the pharmacy entered the Ambien order into Resident #1's profile on the eMAR.<br>-The order was entered on the eMAR to remind the facility they needed to follow up the with resident's physician to get a hard prescription.<br><br>Interview on 11/16/16 at 2:15PM with the Medication Office Assistant (MOA) at Resident #1 physician's office revealed:<br>-The office was not aware Resident #1 was on | D 273 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL049015 | A. BUILDING: _____ B. WING _____ | 11/16/2016 |

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| JURNEY'S ASSISTED LIVING | 1942 VAN HAVEN DRIVE STATESVILLE, NC 28625 |

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| D 273 | Continued From page 12<br>Ambien until the facility called today (11/16/16) to get a hard script.<br>-The physician "came to facility weekly, and if he wrote a prescription there, it would not automatically show up in the records at the office."<br><br>Interview on 11/16/16 at 2:35PM with Resident #1 revealed:<br>-He had trouble sleeping, and had asked the physician for Ambien.<br>-His problem was not falling asleep but staying asleep, and this happened every night.<br>-Waking up did not cause him distress, but "sometimes it was hard to go back to sleep."<br>-He knew his physician had ordered the Ambien, but it was not available.<br>-He was not exactly sure why the facility did not have his Ambien.<br>-He was relieved the Ambien was coming this evening with the pharmacy orders.<br><br>Interview on 11/16/16 at 3:20PM with the facility Administrator revealed:<br>-She was not sure if the facility had a specific policy on contacting residents' physicians in these situations.<br>-The MA should call the pharmacy immediately to find out why a medication was not sent.<br>-Depending on the circumstances, the MA would call the physician to obtain a hard prescription or an alternative if the medication was not covered by a resident's insurance.<br>-The MA would then report this incident to the RCD.<br>-Depending on the medication, the facility may obtain the medication from their back-up pharmacy., e.g. antibiotics. | D 273 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to safe hot water temperatures.<br><br>The findings are:<br><br>Based on record review, observations and resident and staff interviews, the facility failed to ensure hot water temperatures throughout the facility were maintained at or between 100 and 116 degrees Fahrenheit (F), as checked with a calibrated thermometer in 5 of 10 resident bathroom sinks, 2 of 10 resident showers and 2 of 2 common resident sinks [Refer to Tag #113, 10A NCAC 13F .0311(d), Other Requirements (Type B Violation)]. | D912 | It is this community's policy and normal practice to assure water temperatures are within the guidelines outlined at 10A NCAC 13F.0311(d).<br><br>The community had in place policies and procedures designed to maintain these goals.<br><br>Routine monitoring, consultant audits, staff, visitor, resident use and feedback, Quality Assurance audits and meetings, and various other quality assurance measures are examples of the many components utilized.<br><br>Maintenance routinely conducts random water temperature checks throughout the facility on a scheduled basis or more often if an issue were to be suspected and/or identified.<br><br>Since the last water temperature check conducted a few days prior to 11/15/16, residents and staff had not encountered any cold or hot water concerns. Water temperatures were within 100-116 degrees.<br><br>**Action Plan**<br><br>**Measures to Correct**<br>Same plan as D 113<br><br>**Measures to Prevent**<br>See plan as D 113<br><br>**Monitoring**<br>See plan as D 113 | 12/31/16 |

**ATTACHMENT 4**

# Jurney's Assisted Living
# Receipt of Medications Policy & Procedure

Developed 11/22/16

**Purpose:** To assure that all new and existing physician ordered medications are received at the facility in a timely manner and are readily available for administration.

**Procedure:**

**New Medication Orders**

The Resident Care Director or designee is responsible for physically checking and assuring that all new physician ordered medications are in the facility.

- Upon review of all new prescription orders for scheduled or prn medications, the Resident Care Director or designee is responsible for checking the medication cart to assure that the medication is readily available in the facility.
- In the event that the medication has not been received in the facility by the pharmacy, the Resident Care Director or designee is responsible for contacting the pharmacy to determine why the medication has not been received and to assist in troubleshooting the issue.
- The Resident Care Director or designee is responsible for continuing to follow-up with the pharmacy until the medication has been received in the facility.

**Existing, New, and PRN Medication Orders**

- The SIC and MT is responsible for immediately reporting to the Resident Care Director any medication that is not in the facility and readily available for administration.
- The Resident Care Director or designee is responsible for communicating receipt of medication concerns to the pharmacy until a resolution has been reached and the medication has been received in the facility.